

COUNTY OF BLAND
RECIPIENT APPLICATION
SICK LEAVE SHARING PROGRAM

I wish to apply for sick leave donated hours as indicated below.

Applicant Name: _____

SSN or ID #: _____

Department Name: _____

Purpose of Sick Leave Request: _____
(Attach Medical Documentation)

Estimated Length of Absence: _____

I understand:

- That the request for donated sick leave hours must be made prior to leave
- That I must submit this completed form with medical documentation to the Administrator or Deputy Administrator
- That the leave must be for medical reasons only as outlined within the County's Personnel Policy
- That the Bland County Board of Supervisors will make the final determination of approval or denial
- That any sick leave hours or annual leave hours on the books must be exhausted before any donated sick leave hours will be awarded
- That I will be limited to 40 hours per event

Applicant's signature: _____ Date: _____

County Administrator or Deputy Administrator Signature: _____

Date Received: _____